SAMPLE DBA FORM

PAYER
1000 EXAMPLE STREET
SMITH, MO 63857

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 000013235

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, GRACE S.

3. PATIENT'S BIRTH DATE MM DD YY: 02 04 2011 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, EDDIE

5. PATIENT'S ADDRESS (No., Street): 16 OCEAN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 16 OCEAN STREET

CITY: WALTHAM STATE: WA

8. RESERVED FOR NUCC USE

CITY: WALTHAM STATE: WA

ZIP CODE: 98374 TELEPHONE (Include Area Code): (360) 111-0000

ZIP CODE: 98374 TELEPHONE (Include Area Code): (360) 111-0000

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 05 29 1988 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: INSURANCE CARRIER

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 7/30/2014

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN RON EXAMPLE

17a.

17b. NPI 1234567891

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. V061 B. V053 C. V0382 D. V0489
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07 30 2014	07 30 2014	22		90698		A	61 62	1		NPI	1699092718
2	07 30 2014	07 30 2014	22		90744		B	12 10	1		NPI	1699092718
3	07 30 2014	07 30 2014	22		90670		C	117 83	1		NPI	1699092718
4	07 30 2014	07 30 2014	22		90680		D	70 36	1		NPI	1699092718
5	DO NOT USE MODIFIERS										NPI	
6	SEE: WWW.WAVACCINE.ORG FOR LATEST PRICING GRID										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 272251833 [ ] [X]

26. PATIENT'S ACCOUNT NO.: B48532

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 261 91

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHYSICIAN SIGNATURE

SIGNED DATE 7/30/2014

32. SERVICE FACILITY LOCATION INFORMATION
EXAMPLE FACILITY
00 DOCTOR BLVD.
WALTHAM, WA 98374-8846

a. FACILITY NPI b.

33. BILLING PROVIDER INFO & PH # (888) 928-2224
WASHINGTON VACCINE ASSOCIATION
PO BOX 94002
SEATTLE, WA 98124-9402

a. 1699092718 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

VACCINE ADMINISTRATION CLAIM TO SUBMIT WITH DBA FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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17b. NPI

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1 DATE OF SERVICE				PROVIDER CPT		#	$PROVIDER AMOUNT			NPI	PROVIDER NPI
2 DATE OF SERVICE				PROVIDER CPT		#	$PROVIDER AMOUNT			NPI	PROVIDER NPI
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN PROVIDER TIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ TOTAL

29. AMOUNT PAID $

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SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

PROVIDER INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

PROVIDER INFORMATION

a. NPI b.

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